Houston Cancer Treatment & Immunotherapy Center, PLLC

1101 Alma St. Suite 106, Tomball TX 77375
11417 Veterans Memorial Dr., Houston TX 77067
17506 Red Oak Dr., Houston TX 77090
Phone: (832) 336-1853 Fax: (832) 663-0559
Dr. Diane D. Nguyen, DO
Board Certified Medical Oncologist and Hematologist

HOUSTON CANCER TREATMENT & IMMUNOTHERAPY CENTER, PLLC
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

EFFECTIVE 04/2019

This Notice of Privacy Practices (the "*Notice*") tells you about the ways we may use and disclose your protected health information ("*medical information*") and your rights and our obligations regarding the use and disclosure of your medical information. This Notice applies to Houston Cancer Treatment & Immunotherapy Center, PLLC, including its providers and employees (the "*Practice*").

I. HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following categories describe the different reasons that we typically use and disclose medical information. These categories are intended to be general descriptions only, and not a list of every instance in which we may use or disclose your medical information. Please understand that for these categories, the law generally does not require us to get your authorization in order for us to use or disclose your medical information.

A. For Treatment. We may use and disclose medical information about you to provide you with health care treatment and related services, including coordinating and managing your health care. We may disclose medical information about you to physicians, nurses, other health care providers and personnel who are providing or involved in providing health care to you (both within and outside of the Practice). For example, should your care require referral to or treatment by another physician of a specialty outside of the Practice, we may provide that physician with your medical information in order to aid the physician in his or her treatment of you.

B. For Payment. We may use and disclose medical information about you so that we or may bill and collect from you, an insurance company, or a third party for the health care services we provide. This may also include the disclosure of medical information to obtain prior authorization for treatment and procedures from your insurance plan. For example, we may send a claim for payment to your insurance company, and that claim may have a code on it that describes the services that have been rendered to you. If, however, you pay for an item or service in full, out of pocket and request that we not disclose to your health plan the medical information solely relating to that item or service, as described more fully in Section IV of this Notice, we will follow that restriction on disclosure unless otherwise required by law.

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C. For Health Care Operations. We may use and disclose medical information about you for our health care operations. These uses and disclosures are necessary to operate and manage our practice and to promote quality care. For example, we may need to use or disclose your medical information in order to assess the quality of care you receive or to conduct certain cost management, business management, administrative, or quality improvement activities or to provide information to our insurance carriers.

D. Quality Assurance. We may need to use or disclose your medical information for our internal processes to assess and facilitate the provision of quality care to our patients.

E. Utilization Review. We may need to use or disclose your medical information to perform a review of the services we provide in order to evaluate whether that the appropriate level of services is received, depending on condition and diagnosis.

F. Credentialing and Peer Review. We may need to use or disclose your medical information in order for us to review the credentials, qualifications and actions of our health care providers.

G. Treatment Alternatives. We may use and disclose medical information to tell you about or recommend possible treatment options or alternatives that we believe may be of interest to you.

H. Appointment Reminders and Health Related Benefits and Services. We may use and disclose medical information, in order to contact you (including, for example, contacting you by phone and leaving a message on an answering machine, texting you, or emailing you) to provide appointment reminders and other information. We may use and disclose medical information to tell you about health-related benefits or services that we believe may be of interest to you.

I. Business Associates. There are some services (such as billing or legal services) that may be provided to or on behalf of our Practice through contracts with business associates. When these services are contracted, we may disclose your medical information to our business associate so that they can perform the job we have asked them to do. To protect your medical information, however, we require the business associate to appropriately safeguard your information.

J. Individuals Involved in Your Care or Payment for Your Care. We may disclose medical information about you to a friend or family member who is involved in your health care, as well as to someone who helps pay for your care, but we will do so only as allowed by state or federal law (with an opportunity for you to agree or object when required under the law), or in accordance with your prior authorization.

K. As Required by Law. We will disclose medical information about you when required to do so by federal, state, or local law or regulations.

L. To Avert an Imminent Threat of Injury to Health or Safety. We may use and disclose medical information about you when necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. Such disclosure would only be to medical or law enforcement personnel.

M. Organ and Tissue Donation. If you are an organ donor, we may use and disclose medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

N. Research. We may use or disclose your medical information for research purposes in certain situations. Texas law permits us to disclose your medical information without your written authorization to qualified personnel for research, but the personnel may not directly or indirectly identify a patient in any report of the research or otherwise disclose identity in any manner. Additionally, a special approval process will be used for research purposes, when required by state or federal law. For example, we may use or disclose your information to an Institutional Review Board or other authorized privacy board to obtain a waiver of authorization under HIPAA. Additionally, we may use or disclose your medical information for research purposes if your authorization has been obtained when required by law, or if the information we provide to researchers is "de-identified."

O. Military and Veterans. If you are a member of the armed forces, we may use and disclose medical information about you as required by the appropriate military authorities.

P. Workers' Compensation. We may disclose medical information about you for your workers' compensation or similar program. These programs provide benefits for work-related injuries. For example, if you have injuries that resulted from your employment, workers' compensation insurance or a state workers' compensation program may be responsible for payment for your care, in which case we might be required to provide information to the insurer or program.

Q. Public Health Risks. We may disclose medical information about you to public health authorities for public health activities. As a general rule, we are required by law to disclose certain types of information to public health authorities, such as the Texas Department of State Health Services.

R. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, civil, administrative, or criminal investigations and proceedings, inspections, licensure and disciplinary actions, and other activities necessary for the government to monitor the health care system, certain governmental benefit programs, certain entities subject to government regulations which relate to health information, and compliance with civil rights laws.

S. Legal Matters. If you are involved in a lawsuit or a legal dispute, we may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process. In addition to lawsuits, there may be other legal proceedings for which we may be required or authorized to use or disclose your medical information, such as investigations of health care providers, competency hearings on individuals, or claims over the payment of fees for medical services.

T. Law Enforcement, National Security and Intelligence Activities. In certain circumstances**,** we may disclose your medical information if we are asked to do so by law enforcement officials, or if we are required by law to do so. We may disclose your medical information to law enforcement personnel, if necessary to prevent or decrease a serious and imminent threat of injury to your physical, mental or emotional health or safety or the physical safety of another person. We may disclose

medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

U. Coroners, Medical Examiners and Funeral Home Directors. We may disclose your medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about our patients to funeral home directors as necessary to carry out their duties.

V. Inmates. If you are an inmate of a correctional institution or under custody of a law enforcement official, we may disclose medical information about you to the health care personnel of a correctional institution as necessary for the institution to provide you with health care treatment.

W. Marketing of Related Health Services. We may use or disclose your medical information to send you treatment or healthcare operations communications concerning treatment alternatives or other health-related products or services. We may provide such communications to you in instances where we receive financial remuneration from a third party in exchange for making the communication only with your specific authorization unless the communication: (i) is made face-to-face by the Practice to you, (ii) consists of a promotional gift of nominal value provided by the Practice, or (iii) is otherwise permitted by law. If the marketing communication involves financial remuneration and an authorization is required, the authorization must state that such remuneration is involved. Additionally, if we use or disclose information to send a written marketing communication (as defined by Texas law) through the mail, the communication must be sent in an envelope showing only the name and addresses of sender and recipient and must (i) state the name and toll-free number of the entity sending the market communication; and (ii) explain the recipient's right to have the recipient's name removed from the sender's mailing list.

X. Fundraising. We may use or disclose certain limited amounts of your medical information to send you fundraising materials. You have a right to opt out of receiving such fundraising communications. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Y. Electronic Disclosures of Medical Information. Under Texas law, we are required to provide notice to you if your medical information is subject to electronic disclosure. This Notice serves as general notice that we may disclose your medical information electronically for treatment, payment, or health care operations or as otherwise authorized or required by state or federal law.

II. OTHER USES OF MEDICAL INFORMATION

A. Authorizations. There are times we may need or want to use or disclose your medical information for reasons other than those listed above, but to do so we will need your prior authorization. Other than expressly provided herein, any other uses or disclosures of your medical information will require your specific written authorization.

B. Psychotherapy Notes, Marketing and Sale of Medical Information. Most uses and disclosures of "psychotherapy notes," uses and disclosures of medical information for marketing purposes, and disclosures that constitute a "sale of medical information" under HIPAA require your authorization.

C. Right to Revoke Authorization. If you provide us with written authorization to use or disclose your medical information for such other purposes, you may revoke that authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your medical information for the reasons covered by your written authorization. You understand that we are unable to take back any uses or disclosures we have already made in reliance upon your authorization, and that we are required to retain our records of the care that we provided to you.

III. YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

Federal and state laws provide you with certain rights regarding the medical information we have about you. The following is a summary of those rights.

A. Right to Inspect and Copy. Under most circumstances, you have the right to inspect and/or copy your medical information that we have in our possession, which generally includes your medical and billing records. To inspect or copy your medical information, you must submit your request to do so in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

If you request a copy of your information, we may charge a fee for the costs of copying, mailing, or certain supplies associated with your request. The fee we may charge will be the amount allowed by state law.

If your requested medical information is maintained in an electronic format (e.g., as part of an electronic medical record, electronic billing record, or other group of records maintained by the Practice that is used to make decisions about you) and you request an electronic copy of this information, then we will provide you with the requested medical information in the electronic form and format requested, if it is readily producible in that form and format. If it is not readily producible in the requested electronic form and format, we will provide access in a readable electronic form and format as agreed to by the Practice and you.

In certain very limited circumstances allowed by law, we may deny your request to review or copy your medical information. We will give you any such denial in writing. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will abide by the outcome of the review.

B. Right to Amend. If you feel the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by the Practice. To request an amendment, your request must be in writing and submitted to the HIPAA Officer at the address listed in Section VI below. In your request, you must provide a reason as to why you want this amendment. If we accept your request, we will notify you of that in writing.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (i) was not created by us (unless you provide a reasonable basis for asserting that the person or organization that created the information is no longer available to act on the requested amendment), (ii) is not part of the information kept by the Practice, (iii) is not part of the information which you would be permitted to inspect and copy, or (iv) is accurate and complete. If we deny your request, we will notify you of that denial in writing.

C. Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a restriction or limitation on the medical information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend.

Except as specifically described below in this Notice, we are not required to agree to your request for a restriction or limitation. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment. In addition, there are certain situations where we won't be able to agree to your request, such as when we are required by law to use or disclose your medical information. To request restrictions, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI of this Notice below. In your request, you must specifically tell us what information you want to limit, whether you want us to limit our use, disclosure, or both, and to whom you want the limits to apply.

As stated above, in most instances we do not have to agree to your request for restrictions on disclosures that are otherwise allowed. However, if you pay or another person (other than a health plan) pays on your behalf for an item or service in full, out of pocket, and you request that we not disclose the medical information relating solely to that item or service to a health plan for the purposes of payment or health care operations, then we will be obligated to abide by that request for restriction unless the disclosure is otherwise required by law. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information (such as a pharmacy filling a prescription). It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket (and which would not be subject to the restriction).

D. Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at home, not at work or, conversely, only at work and not at home. To request such confidential communications, you must make your request in writing to the Practice's HIPAA Officer at the address listed in Section VI below.

We will not ask the reason for your request, and we will use our best efforts to accommodate all reasonable requests, but there are some requests with which we will not be able comply. Your request must specify how and where you wish to be contacted.

E. Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this Notice, you must make your request in writing to the Practice's HIPAA Officer at the address set forth in Section VI below.

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F. Right to Breach Notification. In certain instances, we may be obligated to notify you (and potentially other parties) if we become aware that your medical information has been improperly disclosed or otherwise subject to a "breach" as defined in and/or required by HIPAA and applicable state law.

IV. CHANGES TO THIS NOTICE.

We reserve the right to change this Notice at any time, along with our privacy policies and practices. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well, as any information we receive in the future. We will post a copy of the current notice, along with an announcement that changes have been made, as applicable, in our office. When changes have been made to the Notice, you may obtain a revised copy by sending a letter to the Practice's HIPAA Officer at the address listed in Section VI below or by asking the office receptionist for a current copy of the Notice.

V. COMPLAINTS.

If you believe that your privacy rights as described in this Notice have been violated, you may file a complaint with the Practice at the following address or phone number:

Houston Cancer Treatment & Immunotherapy Center, PLLC
1101 Alma St. Suite 106
Tomball, TX 77375
(832) 336-1853

To file a complaint, you may either call or send a written letter. The Practice will not retaliate against any individual who files a complaint. You may also file a complaint with the Secretary of the Department of Health and Human Services.

In addition, if you have any questions about this Notice, please contact the Practice's HIPAA Officer at the address or phone number listed above.

By signing below, I certify that I have read and understand this Notice of Privacy Practice.

_____ _____
Patient Name (Please Print) Date

_____ _____
Patient/Legal Representative Signature Date

_____
Relationship to Patient if Legal Representative

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Authorization to Financial Policy

Financial Responsibilities

I hereby authorize Houston Cancer Treatment & Immunotherapy Center, PLLC to release any information acquired in the course of my examination and/or treatment for the purpose of determining eligibility for benefits and claims processing. I hereby authorize the payment directly to Houston Cancer Treatment & Immunotherapy Center, PLLC for the services rendered. I understand that I am financially responsible for any and all charges not covered by this authorization and all outstanding balances maybe referred to collections. It is office policy that due to your insurance policy, you may be billed at a later date. I agree a photographic copy is as valid as the original.

Initials:_____

Assignment of Benefits to Houston Cancer Treatment & Immunotherapy Center, PLLC

Medicare/Medicaid/Champus Patients ONLY:

I hereby authorize Group Medical & Surgical Services to furnish to my physician any information obtained in the adjudication of any claims in regard to the services furnished to me under the Title XVII of the Social Security Act.

Initials:_____

Acknowledgment of Missed Appointment and Returned Check Policy

I understand that Houston Cancer Treatment & Immunotherapy Center, PLLC has the right to charge a non-refundable fee of **$75** for missed appointment(s) and **$30** for check returned unfunded.

Initials:_____

By signing below, you acknowledge that you have received, acknowledge, and consents of the above policies prior to any service being provided to you by the Practice.

_____ _____
Patient Name (Please Print) Date

_____
Patient/Legal Representative Signature

_____
Relationship to Patient if Legal Representative

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Authorization to Release Information and Consent to Treatment

Authorization For Appointment Reminders

I hereby authorize Houston Cancer Treatment & Immunotherapy Center, PLLC to contact me by phone and leave messages on the answering machine, text me, or email me to provide appointment reminders.

Initial: _____

Authorization to View Medication List From E-Prescribing Software

I hereby authorize health care providers of Houston Cancer Treatment & Immunotherapy Center, PLLC to view my medication profile available through e-prescribing software. I understand this list may not be comprehensive and is limited to the medication which have been prescribed to me electronically. It is my responsibility to provide my physician with a complete list of medication I am currently taking.

Initial: _____

Consent For Treatment

I voluntarily give my permission to the health care providers of Houston Cancer Treatment & Immunotherapy Center, PLLC and other health care providers deemed necessary, to provide medical services to me. I understand by signing this form, I am authorizing them to treat me in the duration of my care with Houston Cancer Treatment & Immunotherapy Center, PLLC until I withdraw my consent in writing.

Initial: _____

By signing below, you acknowledge that you have received, acknowledge, and consent to the above policies prior to any service being provided to you by Houston Cancer Treatment & Immunotherapy Center, PLLC.

_____ _____

Patient Name (Please Print): Date

_____

Patient/Legal Representative Signature

_____

Relationship to Patient if Legal Representative

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Credit Card Agreement

In order to provide quality care, excellent service, and more efficiently streamline or billing services and department, we are implementing a Credit Card Agreement.

Your credit card may be obtained and kept securely until your insurance(s) have paid their portion and notifies the clinic staff if there is any patient responsibility or balance due.

HCTAIC Billing Department will send a statement of outstanding balance, which you'll have 30 days to pay or notify the staff of intent to pay. After 30 days, if the bill remains unpaid, we will you're your credit card.

This does not affect your ability to dispute a charge or question your insurance company's determination of payment, receive billing statements from HCTAIC, or receive EOBs from your insurance company.

By signing below, I authorize Houston Cancer Treatment and Immunotherapy Center, PLLC (HCTAIC) to keep my signature and credit card information securely on-file in my account.

I authorize Houston Cancer Treatment and Immunotherapy Center, PLLC to charge my credit card for any outstanding balances, per noted in my insurance's EOB.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to let HCTAIC know and give a new, valid credit card.

I agree that my card may be charged over the telephone and that I may not be there in person.

□ Visa □ MasterCard □ Discover □ American Express

Patient's Name (Print): _____ DOB: ___/___/_____
Name on Card (Print): _____

Credit Card Number: _____ Exp. Date: ___/____ CVV: _____

□ I agree for HCTAIC staff to make a photocopy of my card to keep securely in my account.

Holder's Signature: _____ Date: _____

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Authorization to Release Information to Family Member

Many of our patients allow family members such as their spouse, significant other, parents, children, or siblings to call and request the results of tests, procedures, and financial information. Under the requirements of H.I.P.A.A, we are not allowed to give this information to anyone without the patient's consent.

If you wish to have your medical information, any diagnostic test results and/or financial information released to any family member you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosure in reliance on your prior consent.

I, _____, authorize the health care providers of Houston Cancer Treatment & Immunotherapy Center, PLLC personnel to discuss my health information, in person or by telephone, with the following family members or others directly involved in my medical care:

Name	Phone Number	Relationship
1._____	_____	_____
2._____	_____	_____
3._____	_____	_____
4 ._____	_____	_____
5 ._____	_____	_____

I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

_____ _____
Patient Name (Please Print): Date

_____
Patient/Legal Representative Signature

_____
Relationship to Patient if Legal Representative

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HIPAA Privacy and Release of Information Authorization

PATIENT NAME: _____ DOB: _____

I, _____ hereby authorize of Houston Cancer Treatment & Immunotherapy Center, PLLC and its affiliates, its employees, and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to of Houston Cancer Treatment & Immunotherapy Center, PLLC. However, this authorization may not be revoked if its employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below. By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

_____ _____

Patient Name (Please Print): Date

_____

Patient/Legal Representative Signature

_____

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PATIENT TREATMENT CONSENT FORM

FOR THE ADMINISTRATION OF CHEMOTHERAPY AND NON-CHEMOTHERAPY DRUGS

TO THE PATIENT: As a patient, you have the right to be informed about your condition and the recommended medical or diagnostic procedure or drug therapy to be used so that you can make the informed decision whether or not to take the recommended drug after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, but rather it is an effort to make you better informed so that you may give or withhold your consent to the drug(s) recommended to you by me, as your physician.

I, _____, hereby CONSENT AND AUTHORIZE Dr. DIANE D. NGUYEN or her associates and nurses, as may be delegated by him/her, to administer to me chemotherapy or non-chemotherapy drugs in the form of _____.

My physician has explained to me the diagnosis of my condition, the nature of chemotherapy or non-chemotherapy treatment recommended, the material risks and benefits associated with the treatment, including the alternatives, if any, and the likelihood of success with the treatment as well as the likely outcome of not having the treatment.

I certify that I have read and fully understand the above information and that my physician has provided me with the explanation referred to above. I have had the chance to ask questions about this treatment and my questions have been answered to my satisfaction.

I SPECIFICALLY CONSENT TO THE ADMINISTRATION OF THE CHEMOTHERAPY OR NON-CHEMOTHERAPY DRUG TREATMENT.

_____ _____
Patient Name (Please print) Date/Time

_____
Patient Signature

_____ _____
Physician Signature Date/Time

_____ _____
Nurse Signature Date/Time

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PATIENT TREATMENT CONSENT FORM

FOR THE ADMINISTRATION OF CHEMOTHERAPY AND NON-CHEMOTHERAPY DRUGS

In the event the above-named patient is unable to sign for the following reason(s) (IE medical emergency, patient unconscious incompetence, etc.), the above consent is given on behalf of the patient by:

_____ _____
Relative/Representative Signature Date/Time

_____
Relationship to Patient

_____ _____
Physician Signature Date/Time

_____ _____
Nurse Signature Date/Time

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Records Release Authorization

PATIENT NAME: _____
PREVIOUS NAMES: _____

I authorize Houston Cancer Treatment & Immunotherapy Center, PLLC to:
☐ **receive** ☐ **release my medical information** from/to the below Person/Agency:

_____
Name of Person or Agency

_____
Address

_____
City, State, Zip

_____ _____
Telephone Fax

Please select the following:

☐Consultation Reports	☐EMG Reports	☐Pathology Reports
☐Operative/Surgery Reports	☐Discharge Summary	☐Emergency Records
☐Radiology Reports	☐Lab Reports	☐Progress Reports
☐History & Physical	☐Demographics Information	☐Physical Therapy Notes

☐Other Records: _____

☐Entire Records except: _____

_____ _____
Date of Request Signature of Patient

_____ _____
Date of Birth Address City, State, Zip Code

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Consent to Receive Appointment Reminders and Notifications

By completing this form below, you (The Patient) consent to being contacted by Houston Cancer Treatment and Immunotherapy Center, PLLC (The Practice) by the methods you choose below in order to remind or speak to The Patient regarding their appointments. If in the future you wish to withdraw this consent at any point, please contact the practice in writing.

METHOD OF COMMUNICATION:

Please circle *yes* or *no* and provide the requested information.

Email: _____	YES/NO
Home Phone Number: _____	YES/NO
Cell Phone Number: _____	YES/NO
SMS/Text Messaging	YES/NO
Work Phone Number: _____	YES/NO

_____ _____
Patient Name (Please Print): Date

_____
Patient/Legal Representative Signature

_____
Relationship to Patient if Legal Representative

Houston Cancer Treatment & Immunotherapy Center, PLLC

1101 Alma St. Suite 106, Tomball TX 77375
11417 Veterans Memorial Dr., Houston TX 77067
17506 Red Oak Dr., Houston TX 77090
Phone: (832) 336-1853 Fax: (832) 663-0559
Dr. Diane D. Nguyen, DO
Board Certified Medical Oncologist and Hematologist

Cancellation Policy/No-Show Policy

In order to provide quality care and excellent service, we are implementing a Cancellation and No-Show Policy in order to help our staff better utilize available appointments for our patients waiting for care.

A "no-show" is when a patient misses an appointment without notifying the staff.

We do understand that there are times you may need to cancel due to emergencies or other obligations for work or family. However, if you do not let the staff know and cancel your appointment appropriately, we may be unable to book other patients who need treatment and attention at that slot due to what looks like a "full" clinic schedule. Please help us maintain our goal of excellent service and care by informing the staff when you may need to cancel.

If it is necessary to cancel your appointment, we require a 24 hour notice via phone call, email, or voicemail.

Notification and early cancellation allows other patients the opportunity to have access to timely and quality care.

How to cancel your appointment: Please call our office at (832)336-1853 to speak to any staff member to cancel and reschedule your appointment. If you call after hours or if the line is busy due to staff members taking care of other patients, please leave a message regarding your cancellation (including your name, date of birth, and appointment date and time, as well as your call-back number), and we will return your call and give you the next available appointment time. You may also send us an email via our website, hctaic.org.

Same Day Cancellation Fee: $50.00.

No-Show Fee: $75.00.

These fees will be billed to you and/or collected at the next time of appointment.

_____ _____

Patient Name (Please Print): Date

_____

Patient/Legal Representative Signature

_____

Relationship to Patient if Legal Representative

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PATIENT INFORMATION

PATIENT NAME: _____ DOB:_____ SEX: M F

HOME ADDRESS: _____

BILLING ADDRESS (if different): _____

HOME PHONE: _____ WORK PHONE_____

CELL PHONE: _____ EMAIL: _____

MARITAL STATUS: SINGLE MARRIED DIVORCED SEPARATED WIDOWED

Who do you live with?
ALONE SPOUSE SIGNIFICANT OTHER CHILDREN PARENTS OTHER

OCCUPATION: _____ **EMPLOYER: _____**

RACE: _____ ETHNICITY: _____

PREFERRED LANGUAGE: _____

EMERGENCY CONTACT: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

REFERRING PHYSICIAN: _____

PHONE NUMBER: _____ ADDRESS: _____

PCP: _____ PHONE NUMBER: _____

PHARMACY: _____ PHONE NUMBER: _____

PRIMARY INSURANCE: _____ PHONE NUMBER: _____

MEMBER ID: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARTNER PARENT

SECONDARY INSURANCE: _____ PHONE NUMBER: _____

MEMBER ID: _____ GROUP NUMBER: _____

POLICY HOLDER: _____ DOB: _____

RELATIONSHIP TO PATIENT: SELF SPOUSE PARTNER PARENT

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

PATIENT NAME: _____ DOB: _____

CHIEF COMPLAINT: _____

What were you referred here for? _____
_____
_____

PREVIOUS CANCER: YES NO **If yes, what type? _____**

If yes, circle treatment for previous cancer:

NO TREATMENT SURGERY RADIATION THERAPY CHEMOTHERAPY HORMONAL ABLATIVE

LENGTH OF TREATMENT: _____
PLACEMENT OF TREATMENT: _____

CHEMOTHERAPY DRUGS (Please list all you have taken): _____
_____
_____
_____
_____

RADIATION THERAPY SITE/DURATION: _____
_____
_____

MEDICAL ONCOLOGIST (that you saw previously): _____
_____

RADIATION ONCOLOGIST (that you saw previously): _____
_____

SURGICAL ONCOLOGIST (that you saw previously): _____
_____

STATUS OF PREVIOUS CANCER: ACTIVE REMISSION CURED UNKNOWN

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MEDICAL HISTORY| *Please check all that apply.*

☐ Anxiety	☐ Arthritis	☐ Bipolar Disorder	☐ Cancer
☐ Coagulation Problem	☐ COPD	☐ Depression	☐ Diabetes
☐ GERD	☐ Heart Attack	☐ Heart Problem	☐ Hepatitis
☐ High Cholesterol	☐ HIV/AIDS	☐ Hypertension	☐ Infection
☐ Kidney Problem	☐ Liver Problem	☐ Pneumonia	☐ Renal Problem
☐ Seizure	☐ Stroke	☐ Substance Abuse	☐ Thyroid Problem
☐ Tuberculosis	☐ Other: _____		

_____

_____

SURGERIES| *Please check all that apply and list the year of the procedure.*

☐ Appendectomy| _____	☐ Cataract| _____
☐ Cholecystectomy| _____	☐ Hemorrhoidectomy| _____
☐ Hernia| _____	☐ Hysterectomy| _____
☐ Prostate| _____	☐ Thyroid| _____
☐ Tonsillectomy| _____	☐ Tubal Ligation| _____
☐ Vasectomy| _____	☐ Other: _____

_____

_____

FAMILY HISTORY| *Please check all that apply and list which family members.*

☐ Arthritis| _____	☐ Diabetes| _____
☐ Cancer| _____	☐ Heart Problem| _____
☐ High Cholesterol| _____	☐ Hypertension| _____
☐ Substance Abuse| _____	☐ Other: _____

_____

_____

If there is family history of cancer, please elaborate here:

Relationship to Patient	Type of Cancer
_____	_____
_____	_____
_____	_____
_____	_____

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SOCIAL HISTORY| *Please circle and answer the following questions.*

Smoking History: Never Smoker Former Smoker Current Smoker
If former, how many years smoked? _____
If current, how many packs smoked a day? _____

Alcohol Use: Never Drinks Socially Moderately Heavily

Exercise History: None Limited Moderate Strenuous

Illegal Drug Use: Yes Never Formerly used illegal drugs
If yes or former, please elaborate: _____
_____

ALLERGIES| *Please list all medication and non-medication allergies. If no allergies, write NKDA (No Known Drug Allergies).*

Drug Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Non-Drug Allergy	Reaction
_____	_____
_____	_____
_____	_____

CURRENT MEDICATIONS| *Please list all current medications that you are taking.*

Drug Name & Dose	Frequency	Reason for taking
_____	_____	_____
_____	_____	_____
_____	_____	_____

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_____ _____ _____
_____ _____ _____
_____ _____ _____

GENERAL EVALUATION OF PAIN|

Please notate pain level on a scale of 0 (no pain) to 10 (worst pain imaginable).

Current Pain Level: _____/10

If pain is not relevant, please notate that here: ☐ Pain not relevant.

Pain with no medications: _____/10 Pain with medications: _____/10

Cause of pain: _____
_____

Location of pain: _____
_____

REVIEW OF SYMPTOMS|

General

☐ Normal
☐ Weight Gain| ____ lbs.
☐ Weight Loss| ____ lbs.
☐ Tiredness ☐ Fever
☐ Chills ☐ Night sweats
Energy Levels: ☐ Normal ☐ Improving ☐ Decreased
☐ Other: _____
_____

Skin

☐ Normal
☐ Rash ☐ Itching ☐ Erythema
☐ Skin allergy ☐ Sun burns easily
☐ Bad sun burns in the past
☐ Long term sun exposure
Tanning booth user: ☐ Past ☐ Present
☐ Other: _____
_____

HEENT

☐ Normal
☐ Dry mouth ☐ Hoarseness ☐ Difficult swallowing ☐ Head injury
☐ Blurred vision ☐ Glasses ☐ Glaucoma Artificial Eye: ☐ Left ☐ Right ☐ Both
Blind: ☐ Left ☐ Right ☐ Both Cataracts: ☐ Left ☐ Right ☐ Both
☐ Nasal congestion ☐ Nosebleed ☐ Deviated Septum
Sinusitus: ☐ Seasonal ☐ Acute ☐ Chronic Hearing Aids: ☐ Left ☐ Right ☐ Both
Partial Deafness: ☐ Left ☐ Right ☐ Both Deaf: ☐ Left ☐ Right ☐ Both
☐ Other: _____
_____

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CARDIOVASCULAR/RESPIRATORY

☐ Normal

☐ Abnormal blood pressure	☐ Shortness of breath	☐ Difficulty breathing
☐ Palpitations	☐ Chest Pain	☐ Heart problems
☐ Heart attack	☐ Pacemaker	☐ Stroke
☐ Coronary artery disease	☐ Coughing up blood last 3 times	
☐ Chronic cough	☐ Emphysema	☐ Asthma

☐ Other: _____

_____

BREASTS

☐ Normal

☐ Nipple retraction ☐ Discharge ☐ Lump ☐ Pain

☐ Infection ☐ Last mammography done: _____

☐ Other: _____

_____

GASTROINTESTINAL

☐ Normal

☐ Last bowel movement: _____ ☐ Nausea

☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Rectal pain	☐ Rectal bleeding	☐ Black stool
☐ White stool	☐ Pain in abdomen	☐ Hepatitis
☐ Intestinal polyps	☐ Gastrointestinal parasite	☐ Heartburn
☐ GERD	☐ Incontinence of stool	☐ Screening Colonoscopy: Yes/No

☐ Other: _____

_____

GENITOURINARY

☐ Normal

☐ Pelvic pain	☐ Blood in the urine	☐ Burning when urinating
☐ Obstruction	☐ Incontinence of urine	

☐ Other: _____

_____

GYNECOLOGIC

☐ Pre-Menopause	☐ Menopause at present	☐ Never pregnant
☐ Abnormal vaginal bleeding	☐ Endometriosis	☐ Heavy periods
☐ Prolonged periods	☐ Painful periods	☐ Irregular periods
☐ Abnormal discharge	☐ Painful intercourse	☐ Frequent yeast infections

☐ Other: _____

_____

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MUSCULOSKELETAL/NECK

☐ Normal

☐ Neck pain	☐ Neck stiffness	☐ Neck mass
☐ Back pain	☐ Decreased range of motion	☐ Joint pain
☐ Stiff joints	☐ Swelling in the extremities	☐ Muscle atrophy
☐ Muscle cramps	☐ Muscle weakness	☐ Balance difficulties
☐ Wheelchair-bound		

☐ Other: _____
_____

NEUROLOGICAL

☐ Normal

☐ Headaches	☐ Weakness	☐ Memory loss
☐ Seizures	☐ Paralysis	☐ Numbness
☐ Tingling		

☐ Other: _____
_____

PSYCHIATRIC

☐ Normal

☐ Depression	☐ Anxiety	☐ Bipolar disorder
☐ Insomnia	☐ Suicidal ideation	☐ Homicidal ideation
☐ Impaired cognitive function		

☐ Other: _____
_____

By signing below, I hereby certify all information is true and correct to the best of my knowledge.

_____ _____
Patient Signature Date/Time

_____ _____
Legal Representative Signature Date/Time

_____
Relationship to Patient if Legal Representative

For Office Use Only:

Ht: _____ Wt: _____ Temp: _____

B/P: _____ Pulse: _____ O2: _____